State of Illinois
Department of Central Management Services
Bureau of Benefits

Benefit Choice Options

Enrollment Period May 1 – June 20 2011

State of Illinois

Effective July 1, 2011 - June 30, 2012

Plan Administrators

Who to contact for information

Plan Administrator	Toll-Free Telephone Number	TDD/TTY Number	Website Address
BlueAdvantage HMO	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
PersonalCare HMO	(800) 431-1211	(217) 366-5551	www.personalcare.org
PersonalCare OAP	(800) 431-1211	(217) 366-5551	www.personalcare.org

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Vision Plan	**EyeMed** Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY)	www.eyemedvision care.com/stil
Quality Care Dental Plan (QCDP) Administrator	**Delta Dental of Illinois** Group Number 20240 P.O. Box 5402 Lisle, IL 60532	(800) 323-1743 (800) 526-0844 (TDD/TTY)	http://soi.deltadentalil.com
Life Insurance Plan	**Minnesota Life Insurance Company** 1 N Old State Capitol, Suite 305 Springfield, IL 62701	(888) 202-5525 (800) 526-0844 (TDD/TTY)	www.lifebenefits.com
Flexible Spending Accounts (FSA) Program **Commuter Savings Program (CSP)**	**Fringe Benefits Management Company** A Division of Wageworks P.O. Box 1810 Tallahassee, FL 32302-1810	(800) 342-8017 (800) 955-8771 (TDD/TTY) (850) 514-5817 (fax) (866) 440-7152 (toll-free fax)	www.myFBMC.com
Health/Dental Plans, Medicare COB Unit, FSA and CSP Unit, Premium Collection Unit, Life Insurance, Adoption Benefit and Smoking Cessation Benefit	**CMS Group Insurance Division** 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov

Plan administrator information continued on inside back cover.

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Message to Plan Members

The Benefit Choice Period will be **May 1 through June 20, 2011,** for all members. Members include employees (full-time employees, part-time employees working 50% or greater and employees on leave of absence), annuitants, survivors and COBRA participants. **Elections will be effective July 1, 2011.**

Unless otherwise indicated, all Benefit Choice changes should be made on the Benefit Choice Election Form. Members should complete the form **only if changes** are being made. Your agency/university group insurance representative (GIR) will process the changes based upon the information indicated on the form. Members may obtain GIR names and locations by either contacting the agency's personnel office or viewing the GIR listing on the Benefits website located at **www.benefitschoice.il.gov**.

Members may make the following changes during the Benefit Choice Period:

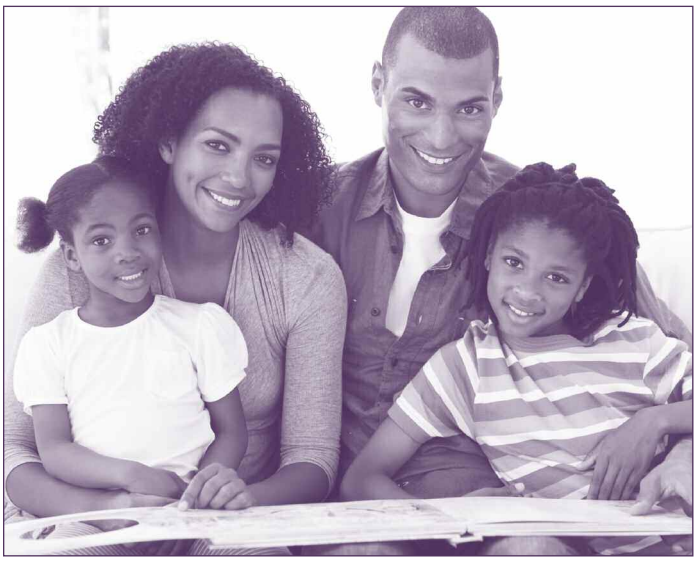
- Change health plans.
- Add or drop dental coverage.
- Add or drop dependent coverage.
- Increase or decrease Member Optional Life insurance coverage.
- Add or drop Child Life, Spouse Life and/or AD&D insurance coverage. **For the FY 2012 Benefit Choice Period only, a statement of health will not be required when adding Child Life coverage.**
- Elect to opt out (full-time employees, annuitants and survivors only). **The election to opt out will terminate the health, dental, vision and prescription coverage for the member and any covered dependents** (see page 29). **Note**: Members must provide proof of other comprehensive health coverage.
- Elect to waive health, dental, vision and prescription coverage (part-time employees 50% or greater, annuitants and survivors required to pay a portion of premiums).
- Re-enroll in the Program if previously opted out (full-time employees, survivors or annuitants). Members have the option of not electing dental coverage upon re-enrollment.
- Re-enroll in the Program if previously waived (part-time employees 50% or greater, annuitants and survivors required to pay a portion of the premium). Members have the option of not electing dental coverage upon re-enrollment.
- Re-enroll in the Program if coverage is currently terminated due to nonpayment of premium while on leave of absence (employees only – subject to eligibility criteria). Any outstanding premiums plus the July premium must be paid before coverage will be reinstated. **Note**: Survivors and annuitants are not eligible to re-enroll if previously terminated for nonpayment of premium.
- Enroll in MCAP and/or DCAP. Employees must enroll each year; previous enrollment in the program does not continue into the new plan year.

Benefit Choice Changes for Plan Year 2012

(Enrollment Period May 1 – June 20, 2011)

The information below represents changes to the State of Illinois benefit plans. Please carefully review all the information in this booklet to be aware of the benefit changes. **The Benefit Choice Period will be May 1 through June 20, 2011.** All elections will be effective July 1, 2011.

- **Managed Care Contracts** – From July 1, 2011, through September 28, 2011, members may choose from the following carriers: HealthLink OAP, PersonalCare OAP, HMO Illinois, BlueAdvantage HMO, Health Alliance HMO, Health Alliance Illinois, PersonalCare HMO or the Quality Care Health Plan. Additional information regarding coverage choices that will be offered after September 28, 2011, will be provided as soon as it is available.



- **Dental Plan** - Effective July 1, 2011, Delta Dental of Illinois will become the plan administrator of the dental program. The Dental Schedule of Benefits and monthly premiums have not changed. Even though Delta Dental offers two provider networks, the Delta Dental PPO℠ network and the Delta Dental Premier℠ network, you can still utilize any licensed general or specialty dentist, regardless of whether the dentist participates in one of the networks, and receive the benefit shown on the Dental Schedule of Benefits. However, in most cases you can reduce your out-of-pocket expenses by utilizing a network provider. See pages 22 and 23 for more information.

  Questions regarding services rendered prior to July 1, 2011, will continue to be handled by CompBenefits at (800) 999-1669.

- **Dependent Children** – Effective July 1, 2011, any dependent child (under age 26) will be eligible for health, dental, vision and life insurance coverage, regardless of student status, marital status or residency. Exception: In accordance with Public Act 95-0958, adult veteran children must live in Illinois in order to be eligible for coverage in the Adult Veteran category. Also, if the adult veteran child is age 26 or older, they must be unmarried. Use the Benefit Choice Enrollment Form on page 31 to enroll a new dependent.

- **Life Insurance** – Life insurance coverage is now available for dependent children under age 26. Due to this expansion of life coverage members will be permitted to enroll ANY of their children under age 26 with Child Life coverage during the Benefit Choice Period without completing a statement of health application. Dependent children added during this period will have Child Life coverage effective July 1, 2011.

Other Plan Year 2012 Changes

- **Student, Student Leave of Absence and Student Military Extension** – Effective July 1, 2011, these dependent categories will no longer be available. Dependents enrolled in any of these categories will automatically be reclassified into the "Sponsored Adult Child" category by CMS during the month of August 2011. **Members do not need to take any action regarding this transition.**

- **Civil Union Partners** – Per Public Act 96-1513, the State of Illinois now requires employers to provide coverage for civil union partners and the dependents of civil union partners. June 1, 2011, will begin a 60-day qualifying change in status enrollment period for those members who have a valid Civil Union Partnership Certificate from another state. For members who obtain a Civil Union Partnership Certificate in Illinois, the 60-day qualifying change in status enrollment period will begin upon the issuance of the certificate. Enrollments will be processed in accordance with qualifying change in status rules.

  Information and FAQs regarding coverage for these individuals can be found on the Benefits website. **As the law permitting civil union partner coverage is not effective until June 1, 2011, coverage for civil union partners and their dependents CANNOT be requested during the Benefit Choice Period.**

- **Domestic Partners** – Effective June 1, 2011, the domestic partner dependent category will no longer be available. The removal of this category is a result of the passage of the State's civil union law. Dependents currently enrolled in this category will continue to have coverage as long as they remain eligible and premiums are paid. New domestic partner dependents CANNOT be added after May 31, 2011.

- **Long-Term Care Insurance** – Effective July 1, 2011, Long-Term Care (LTC) insurance will no longer be offered. Individuals who are currently enrolled in the LTC program will continue to have coverage as long as premiums continue to be paid. Information kits may be obtained from the current vendor until May 31, 2011. New enrollments must be submitted by June 29, 2011. Additional information, including contact information for the current vendor, can be found on the Benefits website.

- **Benefits Handbook** – A new State of Illinois Employees' Benefits Handbook will be released on October 1, 2011. This handbook contains vital information for employees regarding the various benefits offered by the State. The handbook will be available on the Benefits website beginning October 1, 2011.

  A separate benefits handbook will be released for State of Illinois retirees, annuitants and survivors. This handbook will contain much of the same information as the employee handbook; however, it will also contain information specific to our retired members. The Retiree, Annuitant and Survivor Benefits Handbook will be available on the Benefits website beginning October 1, 2011.

- **Federal Healthcare** – The following changes are a result of the Patient Protection and Affordable Care Act.

  1. Preexisting condition limitations no longer apply.
  2. Annual and lifetime maximums have been eliminated.
  3. Residency of a dependent child, except for a dependent child enrolled in the Adult Veteran category, is no longer relevant. Dependent children enrolled in the Adult Veteran category must reside in the State of Illinois to be eligible for coverage.
  4. Marital status of a dependent child under the age of 26 is no longer relevant.
  5. Preventive services are paid at 100%.

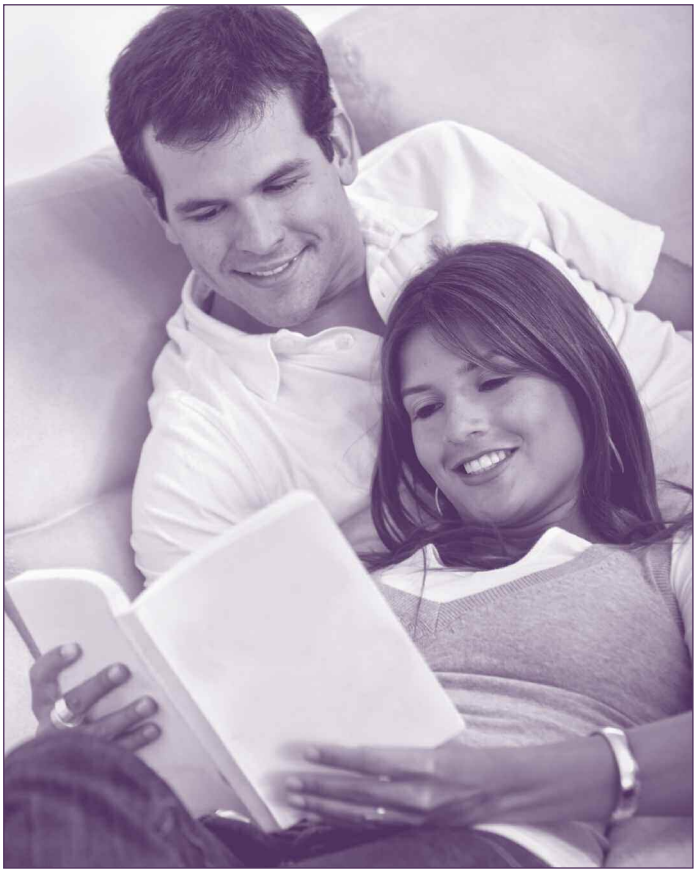
- **Prescription Drug Step Therapy (PDST)** – Beginning July 1, 2011, members enrolled in the Quality Care Health Plan or one of the self-insured managed care plans will be subject to prescription drug step therapy (PDST). PDST is a program designed to encourage members to select lower cost drugs prior to moving to a higher cost therapeutic equivalent. See page 19 for more information.

Member Responsibilities

You must notify the group insurance representative (GIR) at your employing agency, university or retirement system if:

- **You and/or your dependents experience a change of address.**
- **Your dependent loses eligibility.** Dependents that are no longer eligible under the Program (including divorced spouses or partners of a dissolved civil union or domestic partner relationship) must be reported to your GIR immediately. **Failure to report an ineligible dependent is considered a fraudulent act. Any premium payments you make on behalf of the ineligible dependent which result in an overpayment will not be refunded. Additionally, the ineligible dependent may lose any rights to COBRA continuation coverage.**
- **You go on a leave of absence or have time away from work.** When you go on a leave of absence and are not receiving a paycheck or are ineligible for payroll deductions, you are still responsible to pay for your group insurance coverage. You should immediately contact your GIR for your options, if any, to make changes to your current coverage. Requested changes will be effective the date of the written request if made within 60 days of beginning the leave. You will be billed by CMS for the cost of your current coverage. **Failure to pay the bill may result in a loss of coverage and/or the filing of an involuntary withholding order through the Office of the Comptroller.**
- **You have or gain other coverage.** If you have group coverage provided by a plan other than the Program, or if you or your dependents gain other coverage during the plan year.
- **You experience a change in Medicare status.** A copy of the Medicare card must be provided to your GIR when a change in your or your dependent's Medicare status occurs. **Failure to notify the Medicare Coordination of Benefits Unit at Central Management Services of your Medicare eligibility may result in substantial financial liabilities.**
- **You get married or enter into a civil union partnership; or your marriage, domestic partnership or civil union partnership is dissolved.**
- **You have a baby or adopt a child.**
- **The employment status of your spouse, civil union partner or dependent changes.**

Contact your GIR if you are uncertain whether or not a life-changing event needs to be reported.



Member and Dependent Monthly Contributions

While the State covers most of the cost of employee health coverage, employees must also make a monthly salary-based contribution. The salary-based contributions indicated below will begin July 1, 2011, and remain in effect until June 30, 2012. Employees who retire, accept a voluntary salary reduction or return to State employment at a different salary may have their monthly contribution adjusted based upon the new salary (this applies to employees who return to work after having a 10-day or greater break in State service after terminating employment – this **does not** apply to employees who have a break in coverage due to a leave of absence).

Employee Annual Salary	Employee Monthly Health Plan Contributions*	
$30,200 & below	Managed Care: $47.00	Quality Care: $72.00
$30,201 - $45,600	Managed Care: $52.00	Quality Care: $77.00
$45,601 - $60,700	Managed Care: $54.50	Quality Care: $79.50
$60,701 - $75,900	Managed Care: $57.00	Quality Care: $82.00
$75,901 & above	Managed Care: $59.50	Quality Care: $84.50

Note: Employees who reside in Illinois but do not have access to a managed care plan may be eligible for a lower health plan contribution. Contact the CMS Group Insurance Division, Analysis and Resolution Unit at (800) 442-1300 or (217) 558-4671, for assistance.

Retiree, Annuitant and Survivor Monthly Health Plan Contribution

20 years or more of creditable service	$0.00
Less than 20 years of creditable service and, • SERS/SURS annuitant/survivor on or after 1/1/98, or • TRS annuitant/survivor on or after 7/1/99	Required to pay a percentage of the cost of the basic coverage.

Call the appropriate retirement system for applicable premiums.
SERS: (217) 785-7444; SURS: (800) 275-7877; TRS: (800) 877-7896

Monthly Optional Term Life Plan Contributions

Member by Age	Monthly Rate Per $1,000
Under 30	$0.06
Ages 30 - 34	0.08
Ages 35 - 44	0.10
Ages 45 - 49	0.16
Ages 50 - 54	0.24
Ages 55 - 59	0.44
Ages 60 - 64	0.66
Ages 65 - 69	1.28
Ages 70 - 74	2.06
Ages 75 - 79	2.06
Ages 80 - 84	2.06
Ages 85 - 89	2.06
Ages 90 and above	2.06

AD&D Monthly Rate Per $1,000

Accidental Death & Dismemberment	0.02

Spouse Life Monthly Rate

Spouse Life $10,000 coverage (Employees and Annuitants under age 60)	6.00
Spouse Life $5,000 coverage (Annuitants age 60 and older)	3.00

Child Life Monthly Rate

Child Life $10,000 coverage	0.70

Member and Dependent Monthly Contributions

The monthly dependent contribution is **in addition** to the member health plan contribution. Dependents will be enrolled in the same plan as the member. **The Medicare dependent contribution applies only if Medicare is PRIMARY for both Parts A and B.** Members with questions regarding Medicare status may contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit at (800) 442-1300 or (217) 782-7007.

Dependent Monthly Health Plan Contributions*

Health Plan Name and Code	One Dependent	Two or more Dependents	One Medicare A and B Primary Dependent	Two or more Medicare A and B Primary Dependents
Blue Advantage HMO (Code: CI)	$ 80	$110	$ 75	$110
HMO Illinois (Code: BY)	$ 83	$116	$ 79	$116
PersonalCare HMO (Code: AS)	$ 92	$130	$ 88	$130
PersonalCare OAP (Code: CH)	$ 92	$130	$ 88	$130
Health Alliance HMO (Code: AH)	$ 94	$133	$ 89	$133
Health Alliance Illinois (Code: BS)	$103	$145	$100	$145
HealthLink OAP (Code: CF)	$105	$149	$102	$149
Quality Care Health Plan (Code: D3)	$196	$226	$142	$203

Member Monthly Quality Care Dental Plan (QCDP) Contributions*

Member Only	$11.00
Member plus 1 Dependent	$17.00
Member plus 2 or more Dependents	$19.50

* Part-time employees are required to pay a percentage of the State's portion of the contribution in addition to the member contribution. Special rules apply for non-IRS dependents. See the Benefits website for more information.

Health Plan

The State of Illinois offers its employees and annuitants health benefits through the State Employees Group Insurance Program. Prescription, behavioral health and vision coverage are included at no additional cost when enrolled in health coverage. With limited exceptions, the State makes monthly contributions toward your health premiums. Active employees and annuitants should refer to pages 6-7 for the monthly contribution amounts.

As an employee, annuitant or survivor of the State, you are offered a number of health insurance coverage plans:

- Health Maintenance Organizations (HMOs)
- Open Access Plans (OAPs)
- Quality Care Health Plan (QCHP) – a plan with both in-network and out-of-network benefits

The health insurance plans differ in the benefit levels they provide, the doctors and hospitals you can access and the cost to you. See pages 10-15 for information to help you determine which plan is right for you.

You also have the option of opting out of health coverage if you have other comprehensive health coverage provided by an entity other than the Department of Central Management Services. Electing to opt out includes the termination of health, dental, vision, behavioral health and prescription coverage. See page 29 for details. If you do not have other comprehensive health coverage, you must enroll in the State's health plan.

If you change health plans during the Benefit Choice Period, or elect health coverage after opting out, your new health insurance ID cards will be mailed to you directly from your health insurance carrier, not from the Department of Central Management Services. You should expect your new ID cards by the beginning of the plan year, July 1, 2011. If you need to have services provided on or after July 1, 2011, but have not yet received your ID cards, contact your health insurance carrier.

Remember, whatever health plan you elect during the Benefit Choice Period will remain in effect the entire plan year, unless you experience a qualifying change in status that allows you to change plans.

Most expenses that you or your dependent incur outside what your elected health plan covers, such as copayments and deductibles, are reimbursable through the pretax Medical Care Assistance Plan (MCAP). See the Flexible Spending Accounts section on page 25 for details.

Important Reminders

Continuity of Care After Health Plan Change: Members who change health plans and are then hospitalized prior to July 1 and are discharged on or after July 1, or have dependents that are hospitalized, should contact both the current and future health plan administrators and primary care physicians as soon as possible to coordinate the transition of services.

Members or dependents involved in an ongoing course of treatment or who have entered the third trimester of pregnancy should contact the new plan to coordinate the transition of services for treatment.

COBRA Participants: During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other members with the exception of life insurance coverage, which is not available to COBRA participants. COBRA health and dental rates for the 2012 plan year (July 1, 2011 – June 30, 2012) will be available on or after June 1, 2011, by calling (217) 558-6194.

Beneficiary Designations: You should periodically review all beneficiary designations and make the appropriate updates. Remember, you may have death benefits through various state-sponsored programs, each having a separate Beneficiary form:

- State of Illinois life insurance
- Retirement benefits
- Deferred Compensation

Documentation Requirements

- Documentation, including the SSN, is required when adding dependent coverage.
- An approved statement of health is required to add or increase Member Optional Life coverage or to add Spouse Life or Child Life coverage.
- If opting out, proof of other comprehensive health coverage provided by an entity other than the Department of Central Management Services, is required.

Behavioral Health Services

Quality Care Health Plan:
Behavioral health services are now included in an enrollee's annual plan deductible and annual out-of-pocket maximum. Behavioral health services are not subject to separate copayments, limits or other specific provisions. Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the Quality Care Health Plan (QCHP) benefit schedule on pages 14 and 15 for in-network and out-of-network providers. Magellan Behavioral Health is the plan administrator for behavioral health services under QCHP. Please contact Magellan for specific benefit information.

Managed Care Plans:
Behavioral health services are provided under the managed care plans. Covered services for behavioral health must meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedules on pages 12 and 13. Please contact the managed care plan for specific benefit information.

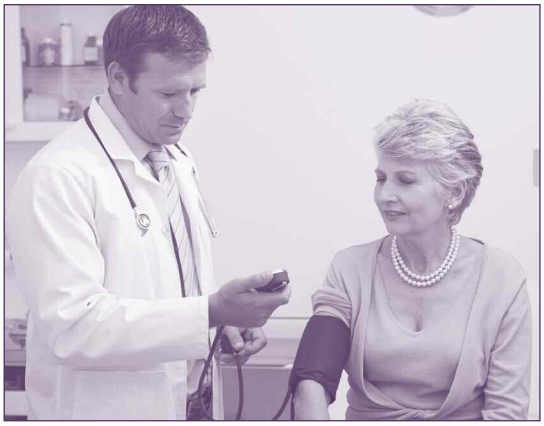
Disease Management Programs and Wellness Offerings

Disease Management Programs:
Disease Management Programs are utilized by CIGNA and the managed care health plans as a way to improve the health of plan participants. You may be contacted by your health plan to participate in these programs.

Wellness Offerings:
Wellness options and preventive measures are offered and encouraged by CIGNA and the managed care plans. Offerings range from health risk assessments to educational materials and, in some cases, discounts on items such as gym memberships and weight loss programs. These offerings are available to plan participants and are provided to help you take control of your personal health and well-being. Information about the various offerings is available on the plan administrators' websites listed on the inside covers of this book and on the Benefits website.

Managed Care Plans

There are several managed care plans available based on geographic location. All offer comprehensive benefit coverage. Distinct advantages to selecting a managed care health plan include lower out-of-pocket costs and virtually no paperwork. Managed care plans have limitations including geographic availability and defined provider networks.



Health Maintenance Organizations (HMOs)

Members must select a primary care physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, only a copayment applies. No annual plan deductibles apply for medical services; however, **there is an annual $50 prescription deductible applied for each plan participant.** The minimum level of HMO coverage provided by all plans is described on page 12. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

Open Access Plans (OAPs)

Open access plans provide three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with copayments and/or coinsurance. Tier III (out-of-network) offers members flexibility in selecting healthcare providers, but requires higher out-of-pocket costs. A deductible applies for medical services under Tier II and Tier III. **Regardless of the tier used, an annual $50 prescription deductible will be applied to each plan participant for prescription coverage.** It is important to remember that the level of benefits is determined by the healthcare provider selected. Members enrolled in an OAP can mix and match providers. Specific benefit levels provided under each tier are described on page 13.

Important Reminders About Managed Care Plans

Primary Care Physician (PCP) Leaves the Network: If a member's PCP leaves the managed care plan's network, the member has three options:

- Choose another PCP within that plan;
- Change managed care plans; or
- Enroll in the Quality Care Health Plan.

The opportunity to change plans applies only to PCPs leaving the network and does not apply to specialists or women's health care providers who are not designated as the PCP.

Provider Network Changes: Managed care plan provider networks are subject to change. Members should always call the respective plan to verify participation of specific providers, even if the information is printed in the plan's directory.

Dependents: Eligible dependents that live apart from the member's residence for any part of a plan year may be subject to limited service coverage. It is critical that members who have an out-of-area dependent (such as a college student) contact the managed care plan to understand the plan's guidelines on this type of coverage.

Plan Year Limitations: Managed care plans may impose benefit limitations based on a calendar year schedule. In certain situations, the State's plan year may not coincide with the managed care plan's plan year.

Behavioral Health Services: Behavioral health services are for the diagnosis and treatment of mental health and/or substance abuse disorders and are available through the member's health plan.

Managed Care Plans in Illinois Counties

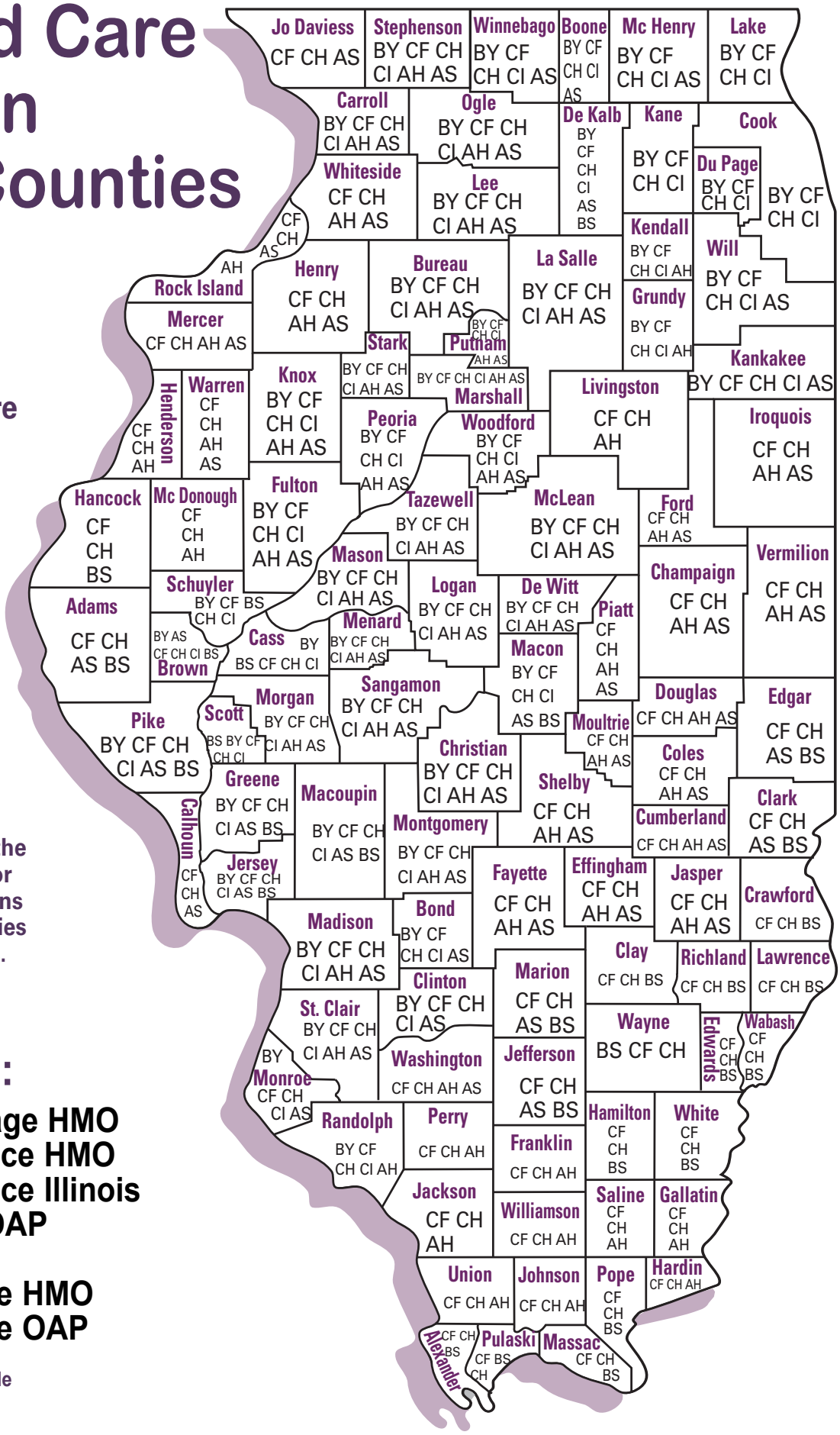
State Managed Care Health Plans For Plan Year 2012

The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their code appears.

HMO & OAP Carrier Codes:

CI = BlueAdvantage HMO
AH = Health Alliance HMO
BS = Health Alliance Illinois
CF = HealthLink OAP
BY = HMO Illinois
AS = PersonalCare HMO
CH = PersonalCare OAP

Note: QCHP available Statewide



HMO Benefits

The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD. A $50 prescription deductible applies to each plan participant (see page 20 for details).

HMO Plan Design

Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited

Hospital Services

Inpatient hospitalization	100% after $275 copayment per admission
Alcohol and substance abuse	100% after $275 copayment per admission
Psychiatric admission	100% after $275 copayment per admission
Outpatient surgery	100% after $175 copayment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after $200 copayment per visit

Professional and Other Services
(Copayment not required for preventive services)

Physician Office visit	100% after $15 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after $20 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after $20 copayment per visit
Prescription drugs ($50 deductible applies; formulary is subject to change during plan year)	$10 copayment for generic $24 copayment for preferred brand $48 copayment for nonpreferred brand
Durable Medical Equipment	80%
Home Health Care	$20 copayment per visit

Some HMOs may have benefit limitations on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan for a copy of the SPD. A $50 prescription deductible applies to each plan participant (see page 20 for details).

Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network) 80% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	Not Applicable	$600 $1,200	$1,500 $3,500
Annual Plan Deductible (must be satisfied for all services)	$0	$200 per enrollee*	$300 per enrollee*
Hospital Services			
Inpatient	100% after $275 copayment per admission	90% of network charges after $325 copayment per admission	80% of U&C after $425 copayment per admission
Inpatient Psychiatric	100% after $275 copayment per admission	90% of network charges after $325 copayment per admission	80% of U&C after $425 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after $275 copayment per admission	90% of network charges after $325 copayment per admission	80% of U&C after $425 copayment per admission
Emergency Room	100% after $200 copayment per visit	100% after $200 copayment per visit	100% after $200 copayment per visit
Outpatient Surgery	100% after $175 copayment per visit	90% of network charges after $175 copayment	80% of U&C after $175 copayment
Diagnostic Lab and X-ray	100%	90% of network charges	80% of U&C
Physician and Other Professional Services (Copayment not required for preventive services)			
Physician Office Visits	100% after $15 copayment	90% of network charges	80% of U&C
Specialist Office Visits	100% after $20 copayment	90% of network charges	80% of U&C
Preventive Services, including immunizations	100%	100%	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after $20 copayment	90% of network charges	80% of U&C
Other Services			
Prescription Drugs – Covered through State of Illinois administered plan, Medco; $50 deductible applies Generic $10 Preferred Brand $24 Non-Preferred Brand $48			
Durable Medical Equipment	100%	90% of network charges	80% of U&C
Skilled Nursing Facility	100%	90% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after $20 copayment	90% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year. Plan copayments, deductibles and amounts over usual and customary (U&C) do not count toward the out-of-pocket maximum.

The Quality Care Health Plan (QCHP)

QCHP (administered by CIGNA) is the medical plan that offers a comprehensive range of benefits. Under the QCHP, plan participants can choose any physician or hospital for medical services; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a QCHP network provider.

The QCHP has a nationwide network (Open Access Plan (OAP)) that consists of physicians, hospitals and ancillary providers. Notification to Intracorp, the QCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction. **Note:** The QCHP is separate from the OAP health plans described on page 13.

QCHP utilizes Magellan for behavioral health benefits and the Medco retail pharmacy network for prescription benefits. A $75 prescription deductible applies to each plan participant (see page 20 for details).

Plan participants can access plan benefit and participating QCHP network information, explanation of benefits (EOB) statements and other valuable health information online. To access website links to plan administrators, visit the Benefits website at **www.benefitschoice.il.gov**.

Plan Year Maximums and Deductibles

Plan Year Maximum Lifetime Maximum	Unlimited Unlimited
Plan Year Deductible	The plan year deductible is based upon each employee's annual salary (see chart below)
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit $400 QCHP hospital admission $50 Non-QCHP hospital admission $300 Transplant deductible $100

Plan Year Deductibles

Employee's Annual Salary (based on each employee's annual salary as of April 1st)	Member Plan Year Deductible	Family Plan Year Deductible Cap
$60,700 or less	$300	$750
$60,701 - $75,900	$400	$1,000
$75,901 and above	$450	$1,125
Retiree/Annuitant/Survivor	$300	$750
Dependents	$300	N/A

Out-of-Pocket Maximums

Deductibles and eligible coinsurance payments accumulate toward the annual out-of-pocket maximum. There are two separate out-of-pocket maximums: In-Network and Out-of-Network. Coinsurance and deductibles apply to one or the other, but not both. After the out-of-pocket maximum has been met, coinsurance amounts are no longer required and the plan pays 100% of eligible charges for the remainder of the plan year.

In-Network: $1,200 per individual $3,000 per family per plan year	Out-of-Network: $4,400 per individual $8,800 per family per plan year

The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits, deductibles or copayments.
- Notification penalties.
- Ineligible charges (amounts over usual and customary (U & C), charges for noncovered services and charges for services deemed not to be medically necessary).
- The portion ($50) of the Medicare Part A deductible the plan participant is responsible to pay.

QCHP - Plan Benefits

Hospital Services	
QCHP Hospital Network	• $50 deductible per hospital admission. • 90% after annual plan deductible.
Non-QCHP Hospitals	• $300 deductible per hospital admission. • 70% of U&C after annual plan deductible.
Outpatient Services	
Preventive Services, including immunizations	100%
Diagnostic Lab/X-ray	90% in-network, 70% of U&C out-of-network, after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	
Licensed Ambulatory Surgical Treatment Centers	
Professional and Other Services	
Services included in the QCHP Network	90% after the annual plan deductible.
Services not included in the QCHP Network	70% of U&C after the annual plan deductible.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	90% in-network, 70% of U&C out-of-network, after annual plan deductible.
Transplant Services	
Organ and Tissue Transplants	90% after $100 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.
Behavioral Health Services	
Magellan administers the QCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see the Benefits Handbook or call Magellan at (800) 513-2611.	

Network providers are subject to change throughout the plan year. Always call the respective plan administrator to verify participation of a specific provider.

Plan Participants (Members and Dependents) Eligible for Medicare

What is Medicare?

Medicare is a federal health insurance program for the following:

- Participants age 65 or older
- Participants under age 65 with certain disabilities
- Participants of any age with End-Stage Renal Disease (ESRD)

Medicare has the following parts to help cover specific services:

- **Medicare Part A** (Hospital Insurance): Part A coverage is a premium-free program for participants with enough earned credits based on their own work history or that of a spouse at least 62 years of age (when applicable) as determined by the Social Security Administration (SSA).
- **Medicare Part B** (Outpatient and Medical Insurance): Part B coverage requires a monthly premium contribution. With limited exception, enrollment is required for members who are retired or who have lost "current employment status" and are eligible for Medicare.
- **Medicare Part C*** (also known as Medicare Advantage): Part C is insurance that helps pay for a combination of the coverage provided in Medicare Parts A, B and D. An individual must already be enrolled in Medicare Parts A and B in order to enroll into a Medicare Part C plan. Medicare Part C requires a monthly premium contribution.
- **Medicare Part D*** (Prescription Drug Insurance): Medicare Part D coverage requires a monthly premium, unless the participant qualifies for extra-help assistance.

In order to apply for Medicare benefits, plan participants are instructed to contact their local SSA office or call (800) 772-1213. Plan participants may also contact the SSA via the internet at www.socialsecurity.gov to sign up for Medicare Part A.

* The State Employees Group Insurance Program **does not require** plan participants to choose a Medicare Part C Plan (over the original Medicare Part A and B option) or to enroll in a Medicare Part D prescription drug plan.

State of Illinois Medicare Requirements

Each plan participant must contact the SSA and apply for Medicare benefits upon turning the age of 65. If the SSA determines that a plan participant is eligible for Medicare Part A at a premium-free rate, the plan participant must accept the Medicare Part A coverage.

If the SSA determines that a plan participant is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the plan participant must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the Medicare COB Unit to avoid a financial penalty. Plan participants who are ineligible for premium-free Medicare Part A benefits, as determined by the SSA are not required to enroll into Medicare Parts A or B.

Employees with Current Employment Status (and their applicable Dependents)

Members who are actively working for the State of Illinois and become eligible for Medicare (or have a dependent that becomes eligible for Medicare) due to turning age 65 or due to a disability (under the age of 65) must accept the premium-free Medicare Part A coverage, but may delay the purchase of Medicare Part B coverage. The State group insurance program will remain the primary insurance for plan participants eligible for Medicare due to age or disability until the date the member retires or loses "current employment status" (such as no longer working due to a disability-related leave of absence). Upon such an event, Medicare Part B is required by the State.

Each plan participant who becomes eligible for Medicare is required to submit a copy of his or her Medicare card to his or her group insurance representative (GIR).

Plan Participants (Members and Dependents) Eligible for Medicare (cont.)

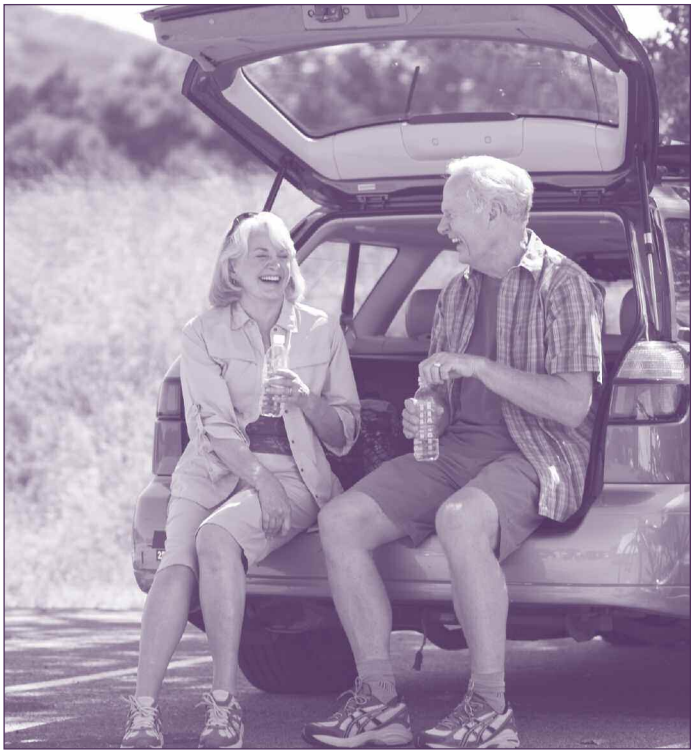
Retirees and Employees without Current Employment Status (and their applicable Dependents)

Members who are retired or who have lost current employment status (such as no longer working due to a disability related leave of absence) and **are eligible for Medicare (or have a dependent that becomes eligible for Medicare) due to turning age 65 or due to a disability (under the age of 65)** must enroll in the Medicare Program. Medicare is the primary payer for health insurance claims over the State group insurance program. **Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary insurance payer will result in a reduction of benefits under the State group insurance plan and will result in additional out-of-pocket expenditures for health-related claims.**

Survivors (and their applicable Dependents)

Survivors (or their dependents) who become eligible for Medicare due to turning age 65 or due to a disability (under the age of 65) must enroll in the Medicare Program. Medicare is the primary payer for health insurance claims over the State group insurance program. **Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary insurance payer will result in a reduction of benefits under the State group insurance plan and will result in additional out-of-pocket expenditures for health-related claims.**

If you are a survivor enrolled in Medicare Part A only, it is imperative that you contact the Medicare COB Unit to discuss the Medicare requirement.



Plan Participants Eligible for Medicare on the Basis of End-Stage Renal Disease (ESRD):

Plan participants who are eligible for Medicare benefits based on End-Stage Renal Disease (ESRD) must contact the State of Illinois Medicare COB Unit for information regarding Medicare requirements and to ensure proper calculation of the 30-month coordination of benefit period.

To ensure that benefits are coordinated appropriately and to prevent financial liabilities with healthcare claims, plan participants must notify the State of Illinois Medicare COB Unit when they become eligible for Medicare. The Medicare COB Unit can be reached by calling (800) 442-1300 or (217) 782-7007.

Prescription Drug Benefit

Plan participants enrolled in any State health plan have prescription drug benefits included in the coverage. All prescription medications are compiled on a preferred formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Each plan maintains a formulary list of medications. These formulary lists are subject to change any time during the plan year. To compare formulary lists, cost-savings programs and to obtain a list of network pharmacies that participate in the various health plans, plan participants should visit the website of each health plan. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified into a different formulary list category. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate. **Regardless of plan chosen, a prescription deductible applies to each plan participant each plan year** **(see page 20).**

Plan participants who have additional prescription drug coverage, including Medicare, should contact their healthcare plan for coordination of benefits (COB) information.

Fully-insured managed care plans (i.e., Blue Advantage, Health Alliance HMO, PersonalCare HMO and HMO Illinois) use a separate prescription benefit manager (PBM) to administer their prescription drug benefits. Members who elect one of these plans must utilize a pharmacy participating in the plan's pharmacy network or the full retail cost of the medication will be charged. Partial reimbursement may be provided if the plan participant files a paper claim with the health plan. It should be noted that most plans do not cover over-the-counter drugs or drugs prescribed by medical professionals, including dentists, other than the plan participant's primary care physician (PCP). It should be noted; however, that drugs prescribed by a specialist would also be covered provided that the plan participant was referred to the specialist by their PCP. **Members should direct prescription benefit questions to the respective health plan administrator.**

Self-insured managed care plans (i.e., HealthLink OAP, Health Alliance Illinois and PersonalCare OAP) **and the Quality Care Health Plan (QCHP)** have prescription drug benefits administered through the prescription benefit manager (PBM), Medco. Prescription drug benefits are independent of other medical services and are not subject to the medical plan year deductible or out-of-pocket maximums. In order to receive the best value, plan participants enrolled in one of these plans should carefully review the various prescription networks outlined on page 19. Most drugs purchased with a prescription from a physician or a dentist are covered; however, over-the-counter drugs are not covered, even if purchased with a prescription. If a plan participant elects a brand name drug and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, in addition to the generic copayment.

Special Note Regarding Medications for Nursing Home/Extended Care Facility QCHP Patients

Due to the large amounts of medication generally administered at nursing home and extended care facilities, many of these types of facilities cannot maintain more than a 30-day supply of prescriptions per patient.

In order to avoid being charged a double-copayment for a 30-day supply, the patient or person who is responsible for the patient's healthcare (such as a spouse, power of attorney or guardian) should submit a letter requesting an 'exception' to the double copayment for their medication. The request should be in the form of a letter, and must include the patient's name, a list of all medications the patient is taking and the dosage of each medication. The effective date of the exception is the receipt date of the request. Requests must be submitted to the Group Insurance Division, Member Services Unit, 201 E. Madison, P.O. Box 19208, Springfield, Illinois 62794-9208.

Note: Since each request is based on a specific list of medications, any newly prescribed medication(s) must be sent as another request.

Medco: (800) 899-2587
Website: www.medco.com

Self-insured Managed Care Plans and QCHP Prescription Drug Benefit

Nonmaintenance Medication

In-Network Pharmacy - Retail pharmacies that contract with Medco and accept the copayment amount for medications are referred to as in-network pharmacies. Plan participants who use an in-network pharmacy must present their Medco ID card/number or they will be required to pay the full retail cost. If, for any reason, the pharmacy is not able to verify eligibility (submit claim electronically), the plan participant must submit a paper claim to Medco. The maximum supply of **nonmaintenance medication** allowed at one fill is 60 days, although two copayments will be charged for any prescription that exceeds a 30-day supply. A list of in-network pharmacies, as well as claim forms, are available on the Benefits website.

Out-of-Network Pharmacy - Pharmacies that do not contract with Medco are referred to as out-of-network pharmacies. In most cases, prescription drug costs will be higher when an out-of-network pharmacy is used. If a medication is purchased at an out-of-network pharmacy, the plan participant must pay the full retail cost at the time the medication is dispensed. Reimbursement of eligible charges may be obtained by submitting a paper claim and the original prescription receipt to Medco. Reimbursement will be provided at the applicable brand or generic in-network price minus the appropriate in-network copayment. Claim forms are available by visiting the Benefits website.

Maintenance Medication

The Maintenance Medication Program (MMP) was developed to provide an enhanced benefit to plan participants who use **maintenance medications.** Maintenance medication is medication that is taken on a regular basis for conditions such as high blood pressure and high cholesterol. To determine whether a medication is considered a maintenance medication, contact a Maintenance Network pharmacist or contact Medco. A list of pharmacies participating in the Maintenance Network is available at **www.benefitschoice.il.gov**. When plan participants use **either** the Maintenance Network or the Medco Pharmacy for maintenance medications, they will receive a **90-day supply of medication (equivalent to 3 fills) for only two copayments**.

The Maintenance Network is a network of retail pharmacies that contract with Medco to accept the copayment amount for maintenance medication. Pharmacies in this network may also be an in-network retail pharmacy as described in the Nonmaintenance Medication section. If a plan participant uses an in-network pharmacy not part of the Maintenance Network, only the first two 30-day fills will be covered at the regular copayment amount. Subsequent fills will be charged double the copayment rate.

The Medco Pharmacy provides participants the opportunity to receive medications directly from Medco. **Both maintenance and nonmaintenance medications may be obtained through the mail order process.**

To utilize the Medco Pharmacy, plan participants must submit an original prescription from the attending physician. For maintenance medication, the prescription should be written for a 90-day supply, and include up to three 90-day refills, totaling one year of medication. The original prescription must be attached to a completed Medco mail order form and sent to the address indicated on the form. Order forms and refills can be obtained by contacting Medco.

Prescription Drug Step Therapy

Effective July 1, 2011, members who have their prescription drug benefits administered through QCHP or one of the self-insured managed care plans whose prescription benefit manager (PBM) is Medco, will be subject to a coverage tool called prescription drug step therapy (PDST) for specific drugs. PDST requires the member to first try one or more specified drugs to treat a particular condition before the plan will cover another (usually more expensive) drug that their doctor may have prescribed. PDST is intended to reduce costs to both the member and the plan by encouraging the use of medications that are less expensive but can still treat the member's condition effectively.

Members who are taking a medication that requires step therapy will receive a letter explaining that the plan will not cover that particular medication unless the alternative medication is tried first. The letter will also have directions on how a member's physician may request a coverage review if the physician believes they should take the original medication without trying the alternative medication first.

Prescription Drug Benefit Copays and Deductibles

Formulary lists categorize drugs in three levels: generic, preferred brand and nonpreferred brand. Each level has a different copayment amount. A plan year deductible applies to each plan participant covered by the health plan. **A new deductible will be required for the member and all covered dependents if the member changes health plans during the plan year.**

PRESCRIPTION DRUG COPAYS FOR A 30-DAY SUPPLY

	PRESCRIPTION PLAN	
	QCHP	All Other Plans
Generic	$11	$10
Preferred (Formulary) Brand	$26	$24
Nonpreferred Brand	$52	$48
Deductible	$75	$50

PRESCRIPTION DRUG DEDUCTIBLE – APPLIES TO ALL PLANS

All plan participants are responsible for a prescription deductible. **Plan participants enrolled in a managed care plan have an annual prescription deductible of $50; plan participants enrolled in the Quality Care Health Plan have an annual prescription deductible of $75.** Annual prescription deductibles must be satisfied before the prescription copayments apply. However, if the cost of the prescription is less than the plan's copayment, the plan participant will pay the cost of the prescription.

Example I – Generic Drug Costs Less than the Deductible

	Total Cost of Drug	Deductible Applied	Deductible Remaining	Copayment	Total Payment
QCHP First Fill	$55	$55	$20	$0	$55
QCHP Next Fill	$55	$20	$0	$11	$31
Managed Care First Fill	$37	$37	$13	$0	$37
Managed Care Next Fill	$37	$13	$0	$10	$23

Example 2 – Generic Drug Costs More than the Deductible

	Total Cost of Drug	Deductible Applied	Deductible Remaining	Copayment	Total Payment
QCHP First Fill	$100	$75	$0	$11	$86
QCHP Next Fill	$100	$0	$0	$11	$11
Managed Care First Fill	$100	$50	$0	$10	$60
Managed Care Next Fill	$100	$0	$0	$10	$10

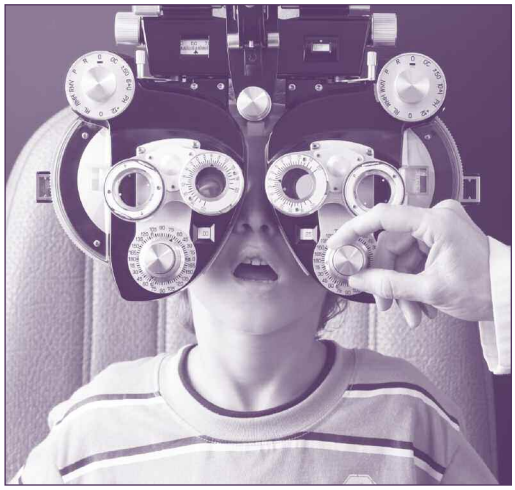
Vision Plan

Vision coverage is provided at no additional cost to members enrolled in any of the State-sponsored health plans. All members and enrolled dependents have the same vision coverage regardless of the health plan selected. Eye exams are covered once every 12 months from the last date the exam benefit was used. All other benefits are available once every 24 months from the last date used. Copayments are required.

Service	Network Provider Benefit	Out-of-Network** Provider Benefit	Benefit Frequency
Eye Exam	$10 copayment	$30 allowance	Once every 12 months
Spectacle Lenses* (single, bifocal and trifocal)	$10 copayment	$50 allowance for single vision lenses $80 allowance for bifocal and trifocal lenses	Once every 24 months
Standard Frames	$10 copayment (up to $175 retail frame cost; member responsible for balance over $175)	$70 allowance	Once every 24 months
Contact Lenses (All contact lenses are in lieu of standard frames and spectacle lenses)	$120 allowance	$120 allowance	Once every 24 months

* Spectacle Lenses: Plan participant pays any and all optional lens enhancement charges. Network providers may offer additional discounts on lens enhancements and multiple pair purchases.

** Out-of-network claims must be filed within one year from the date of service.



EyeMed Vision Care: (866) 723-0512
TDD/TTY: (800) 526-0844
Website: www.eyemedvisioncare.com/stil

Dental Options

All members and enrolled dependents have the same dental benefits available regardless of the health plan selected. During the Benefit Choice Period, members have the option to add or drop dental coverage. **The election to add or drop dental coverage will remain in effect the entire plan year, without exception.**

Plan participants can access Quality Care Dental Plan (QCDP) network information, explanation of benefits (EOB) statements and other valuable information online.

Dental Benefit

The QCDP is a dental plan that offers a comprehensive range of benefits. Effective July 1, 2011, the QCDP will be administered by Delta Dental of Illinois. **The monthly premium and the Dental Schedule of Benefits are not changing for FY 2012.** The QCDP reimburses only those services listed on the Dental Schedule of Benefits (available on the Benefits website). Listed services are reimbursed at a predetermined maximum scheduled amount. Each plan participant is subject to an annual plan deductible for all dental services, except those listed in the Schedule of Benefits as 'Diagnostic' or 'Preventive'. The annual plan deductible is $125 per participant per plan year. Once the deductible has been met, the plan participant has a maximum annual dental benefit of $2,500 for all dental services.

Deductible and Plan Year Maximum

Annual Deductible for Preventive Services	N/A
Annual Deductible for All Other Covered Services	$125
Plan Year Maximum Benefit*	$2,500

* Orthodontics + all other covered services

Plan participants enrolled in the dental plan can choose any dental provider for services; however, plan participants may pay less out-of-pocket when they receive services from a network dentist. There are two separate networks of dentists that a plan participant may utilize for dental services in addition to out-of-network providers: the Delta Dental PPO℠ network and the Delta Dental Premier℠ network.

- **The Delta Dental PPO Network:** If you go to a PPO dentist, your out-of-pocket expenses will often be less because these providers accept a reduced PPO fee (less any deductible). If the PPO fee is lower than the amount listed on the Schedule of Benefits, the PPO dentist cannot bill you for the difference.

- **The Delta Dental Premier Network:** If you go to a Premier dentist, your out-of-pocket expenses may also be less because Premier providers accept the allowed Premier fee (less any deductible). If the allowed fee is lower than the amount listed on the Schedule of Benefits, the Premier dentist cannot bill you for the difference.

- **Out-of-Network:** If you go to a dentist who does not participate in either the PPO or Premier network, you will receive the same benefits that you currently receive; however, you may have to pay more than you would if you went to a Delta Dental network dentist. Out-of-network dentists will charge you for the difference between their submitted fee and the amount listed on the Schedule of Benefits.

Provider Payment

If you use a Delta Dental network dentist, you will not have to pay the dentist at the time of service (with the exception of applicable deductibles, charges for noncovered services, charges over the amount listed on the Schedule of Benefits and/or amounts over the annual maximum benefit). Network dentists will automatically file the dental claim for their patients. Participants who use an out-of-network dentist may have to pay the entire bill at the time of service and/or file their own claim form depending on the payment arrangements the plan participant has with their dentist. **When using an out-of-network dentist, insurance payments will be sent directly to the member and the member is responsible for paying the dentist.**

Delta Dental: (800) 323-1743
TDD/TTY (800) 526-0844
Website: http://soi.deltadentalil.com

Dental Options (cont.)

Example of PPO, Premier and Out-of-Network Dentist Payments *(this is a hypothetical example only and assumes all deductibles have been met).*

Delta Dental PPO Dentist*		Delta Dental Premier Dentist*		Out-of-Network Dentist	
Dentist submitted fee	$1,000	Dentist submitted fee	$1,000	Dentist submitted fee	$1,000
PPO allowed fee	$600	Premier maximum allowed fee	$900	No negotiated fee	n/a
Schedule of Benefits amount	$781	Schedule of Benefits amount	$781	Schedule of Benefits amount	$781
Your Out-of-Pocket Cost	**$0**	**Your Out-of-Pocket Cost**	**$119**	**Your Out-of-Pocket Cost**	**$219**

* When utilizing a PPO or Premier dentist, if the maximum allowed fee is greater than the amount listed on the Schedule of Benefits, the network dentist can bill the member the difference between the two amounts.

Child Orthodontia Benefit

The child orthodontia benefit is available only to children who begin treatment prior to the age of 19. The maximum lifetime benefit for child orthodontia is $2,000. This lifetime maximum is subject to course of treatment limitations (see 'Length of Orthodontia Treatment' chart below).

Members who have children who are currently undergoing orthodontia treatment which began prior to July 1, 2011, should contact their orthodontist's office and request that they submit the original orthodontia treatment plan to Delta Dental for reimbursement purposes. Members who use an out-of-network provider may be required to pay for services up front. Delta Dental will reimburse the member (not the provider) for the insurance portion of the services. Reimbursements will be subject to the claims hold.

Orthodontia Services

Annual Deductible*	$125
Maximum Lifetime Orthodontia Benefit	$2,000

* The annual plan year deductible will need to be satisfied unless it was previously satisfied for other dental services incurred during the plan year.

Length of Orthodontia Treatment

The lifetime maximum benefit for child orthodontics is based on the length of treatment. This lifetime maximum applies to each plan participant regardless of the number of courses of treatment.

Length of Treatment	Maximum Benefit
0 - 36 Months	$2,000
0 - 18 Months	$1,820
0 - 12 Months	$1,040

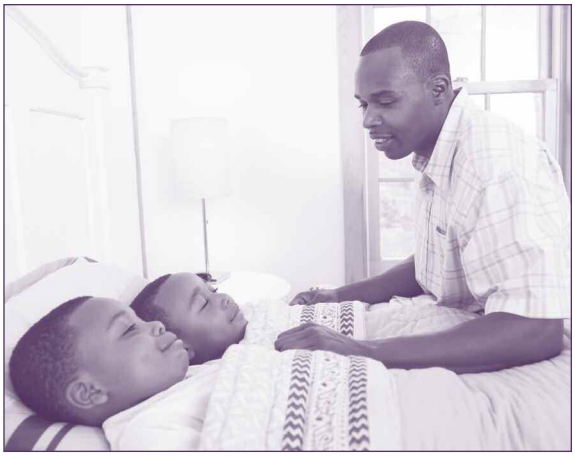
Prosthodontic Limitations

(Prosthodontics include full dentures, partial dentures, implants and crowns)

- Prosthodontics to replace missing teeth are covered only for teeth that are lost while the plan participant is covered by this plan.
- Multiple procedures are subject to limitations. Please refer to the Dental Schedule of Benefits PRIOR to the start of any procedure to clarify coverage limitations.

Life Insurance Plan*

Basic Life insurance is provided at no cost to annuitants and active employees. This term life coverage is provided in an amount equal to the annual salary of active employees. The Basic Life amount for annuitants under age 60 is equal to the annual salary as of the last day of active State employment. For annuitants age 60 or older, the Basic Life amount is $5,000. The life insurance plan offers eligible members the option to purchase additional life insurance to supplement the Basic Life insurance provided by the State.



Member Optional Life

Member Optional Life coverage is available to eligible members. Annuitants under age 60 and active employees can elect coverage in an amount equal to 1-8 times their Basic Life amount; annuitants age 60 and older can elect 1-4 times their Basic Life amount. Members enrolled with Member Optional Life coverage should review the chart on page 6 to be aware of rate variations among age groups. Rate changes due to age go into effect the first pay period following the member's birthday.

The maximum benefit allowed for Member Optional Life plus Basic Life coverage is $3,000,000.

Accidental Death & Dismemberment

Accidental Death and Dismemberment (AD&D) coverage is available to eligible members in either (1) an amount equal to their Basic Life amount or (2) the combined amount of their Basic and Member Optional Life, subject to a total maximum of five times the Basic Life insurance amount or $3,000,000, whichever is less.

Spouse Life

Spouse Life coverage is available in a lump sum amount of $10,000 for the spouse of active employees and annuitants under age 60. Spouse Life coverage decreases to $5,000 for annuitants age 60 and older. A corresponding premium applies.

Child Life

Child Life coverage is available in a lump sum amount of $10,000 for each child. The monthly contribution for Child Life coverage applies to **all** dependent children regardless of the number of children enrolled. Eligible children include:

- Children age 25 and under
- Children in the Disabled category

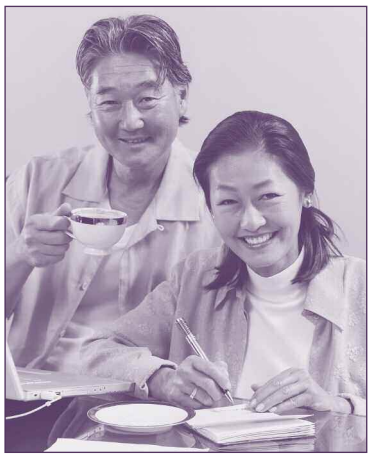
During the FY 2012 Benefit Choice Period, no statement of health will be required to add Child Life coverage for children age 25 and under.

Statement of Health

Adding/increasing Member Optional Life, as well as adding Spouse Life coverage, is subject to prior approval by the life insurance plan administrator, Minnesota Life Insurance Company. Members must complete and submit a statement of health form to Minnesota Life for review. For the FY 2012 Benefit Choice Period only, Child Life coverage may be added without statement of health approval.

* Deferred Annuitants and Survivors have different life insurance benefits. Contact your retirement system for details. Effective June 1, 2011, Spouse Life will cover civil union partners and Child Life will cover the children of civil union partners. No statement of health will be required for newly-acquired civil union partners or the dependents of a civil union partner added after June 1, 2011.

The Flexible Spending Accounts (FSA) Program



Employee Benefit Only - Does NOT Apply to Annuitants

During the Benefit Choice Period, employees may enroll in a Flexible Spending Accounts (FSA) Program with an effective date of July 1, 2011. The great advantage is that you pay **no federal taxes** on your contributions. For example, if you put in $1,000 and are in a 20% federal tax bracket, you save $200 ($1,000 x 20% = $200) over the course of the plan year.

FSA plan elections do not automatically carry over each year. You must complete a new FSA Enrollment Form each year to participate. The minimum monthly amount for which an employee may enroll is $20; the maximum monthly amount is $416.66 ($555.54 for university employees paid over 9 months). The first deduction for an FSA enrollment will be taken on a pretax basis from the first paycheck issued in July. Employees should carefully review their paycheck to verify the deduction was taken correctly. If you do not see the deduction on your paycheck stub, please contact your payroll office immediately.

Medical Care Assistance Plan (MCAP)

What is it? The Medical Care Assistance Plan (MCAP) is a program that allows you to set aside money, before taxes, from your paycheck to pay for **health-related expenses not covered by insurance.** If you, or someone in your family (i.e., spouse and/or eligible dependents), goes to the doctor or dentist, takes medication or wears glasses, whether you have insurance or not, MCAP may save you money. Please note that dependents must qualify under the Internal Revenue Code in order for their healthcare expenses to be eligible for reimbursement.

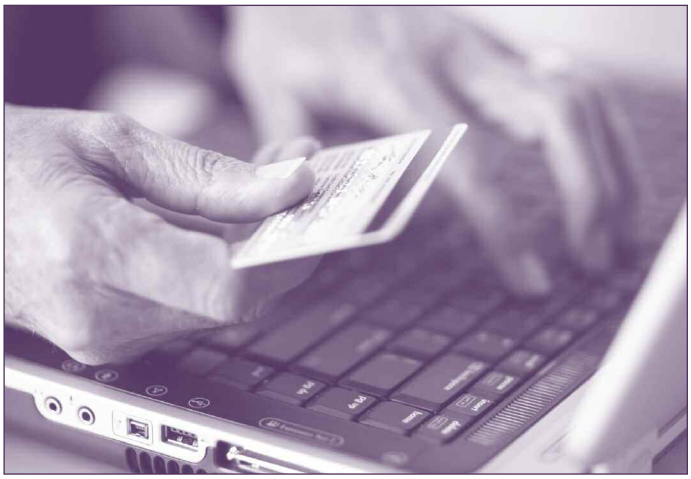
How much should I contribute? Contributions depend on household needs—think about how many copays you will have for physician visits or prescriptions. Will you pay a deductible? Perhaps you expect a large dental, orthodontic (e.g., braces) or vision expense (e.g., LASIK surgery).

Examples of expenses you cannot claim:

- Cosmetic services, vitamins, supplements
- Insurance premiums
- Vision warranties and service contracts
- Over-the-counter medicines and drugs are not eligible for reimbursement without a prescription

Employees who enroll in MCAP are issued the MyFBMC Visa® card at no cost to use for their plan year medical expenses (employees who already have the card will not be issued a new card). Documentation is required to substantiate certain expenses paid with the card; therefore, you should review your monthly statement from the plan administrator, FBMC, carefully to ensure you are aware of the documentation requirements.

You have until September 30, 2012, to submit claims for expenses that were incurred from July 1, 2011, through September 15, 2012; otherwise, any money left in your account will be forfeited.



The Flexible Spending Accounts (FSA) Program

Dependent Care Assistance Plan (DCAP)

The Dependent Care Assistance Plan (DCAP) is for the reimbursement of eligible child care expenses, such as daycare. DCAP cannot be used for dependent healthcare expenses. Employees interested in having their dependent's health-related expenses reimbursed through a pretax program should refer to the Medical Care Assistance Plan (MCAP) on page 25.*

What is it? The Dependent Care Assistance Plan (DCAP) is a program that allows you to set aside money, before taxes, from your paycheck to pay primarily for **child care expenses* of dependent children 12 years and under.** If you (and your spouse, if married), work full-time and pay for daycare, day camp or after-school programs, then DCAP may save you money.

Please note that if you claim the dependent care tax credit, the credit will be reduced, dollar for dollar, by the amount you contribute to DCAP. Also, depending on your household income, it might be advantageous to claim child care expenses on your federal income tax return instead of using DCAP. You cannot claim the expenses on your tax return and use DCAP. Please ask your tax adviser which plan is best for you.

* In addition to child care, DCAP can be used to pay for the dependent care expenses for any individual living with you that is physically or mentally unable to care for themselves and is eligible to be claimed as a dependent on your taxes. Refer to the Internal Revenue Code to ensure your dependent qualifies as a tax dependent before enrolling in this program .

How much should I contribute? Contributions depend on household needs—think about how much you spend on child care every year. Will you use daycare or a private nanny? Perhaps your child is going to nursery school or day camp this year.

Examples of expenses you cannot claim:

- Overnight camp
- Daycare provided by another dependent
- Daycare provided "off the books"
- Kindergarten tuition
- Private primary school tuition
- Before and after-school care expenses for dependents age 13 and older.

You have until September 30, 2012, to submit claims for services incurred from July 1, 2011, through June 30, 2012; otherwise, any money left in your account will be forfeited.

FBMC: (800) 342-8017
TDD/TTY: (800) 955-8771
Website: www.myFBMC.com

Commuter Savings Program (CSP)

Employee Benefit Only - Does NOT Apply to Annuitants or University Employees

The Commuter Savings Program (CSP) is a qualified transportation benefit that allows **employees** to pay for eligible transit and/or parking expenses associated with their work commute through payroll deductions. These deductions will be taken before any Federal, State, FICA or Medicare taxes, resulting in more money in your pocket! The pretax limit for calendar year 2011 for both the transit and parking benefit is $230.00 per month. **The CSP program is only available to employees who are paid through the Comptroller's Office. CSP benefits may be elected, changed or cancelled anytime.**

Parking Benefit

What is it? The CSP parking benefit allows you to pay for the parking costs associated with your work with pretax dollars. You can choose to have the payment for your parking expenses sent directly to your parking provider, or you can choose to be reimbursed for your parking expenses.

How does paying the garage/lot directly work? If you choose to have your parking lot or garage paid directly, the vendor will mail the payment to your parking provider prior to the benefit month. Your agency will then take payroll deductions beginning the first pay period of the benefit month. The deadline to enroll is the 10th of the month prior to the benefit month.

Example: Trisha parks at Joe's Parking Garage. The monthly fee to park is $200. Trisha decides to save some money pretax and enrolls in the CSP prior to the July 10th cut-off date for the August benefit month. The vendor sends Trisha's August parking fees to Joe's Garage at the end of July. Since Trisha is paid on a semi-monthly basis, her agency will take the first payroll deduction of $100.00 from the August 1-15 pay period.

How does the reimbursement option work? Employees who park in a different lot each day or who plug a meter on a street may want to be reimbursed for their parking expenses. No receipts are required. Simply log on to www.myFBMC.com and click on 'My CSP – Reimburse Me' and follow the prompts. Your reimbursement check will be sent directly to your house, or you may sign up for direct deposit.

Transit Benefit

What is it? The CSP transit benefit allows you to pay mass transit costs associated with your work commute with pretax dollars. To enroll, just go online to www.myFBMC.com and register. After you register, click on 'My CSP' and follow the prompts.

How does it work? Once you are enrolled, you will receive your monthly benefit from the vendor prior to the benefit month. Your agency will then take payroll deductions beginning with the first pay period of the benefit month. The deadline to enroll is the 10th of the month prior to the benefit month.
Example: Tom rides the METRA from Glen Ellyn to Ogilvie Center each day. A monthly transit pass for this commute is $116.10. Tom enrolled prior to July 10th for the August benefit month. The vendor sent Tom's August transit pass to his home on July 23rd for him to use on or after August 1st. Since Tom is paid semi-monthly, his agency will take the first payroll deduction of $58.05 from the August 1-15 pay period.

FBMC: (800) 342-8017
TDD/TTY: (800) 955-8771
Website: www.myFBMC.com

Optional Programs

Employee Assistance Program

Employee Benefit Only – Does not apply to Annuitants
There are two separate programs that provide valuable resources for support and information during difficult times for active employees and their dependents: the Employee Assistance Program (EAP) and the Personal Support Program (PSP).

The Employee Assistance Program (EAP) is for active employees NOT represented by the collective bargaining agreement between the State and AFSCME Council 31. These employees must contact the EAP administered by Magellan Behavioral Health.

The Personal Support Program (PSP) is for bargaining unit employees represented by AFSCME Council 31 and covered under the master contract agreement between the State of Illinois and AFSCME. These employees must access EAP services through the AFSCME Personal Support Program.

Both programs are free, voluntary and provide problem identification, counseling and referral services to employees and their covered dependents regardless of the health plan chosen. All calls and counseling sessions are confidential, except as required by law. No information will be disclosed unless written permission is received from the employee. Management consultation is available when an employee's personal problems are causing a decline in work performance. See the inside back cover for website and other contact information.

Adoption Benefit Program

Employee Benefit Only – Does not apply to Annuitants
State employees working full-time or part-time (50% or greater) may request reimbursement of eligible adoption expenses. The adoption must be final before reimbursement may be requested. The request for reimbursement must be received within one year from the end of the plan year in which the adoption became final.

Smoking Cessation Program

Benefit applies to all Members
Members and dependents are eligible to receive a rebate up to $200 for completing an approved smoking cessation program, limited to one rebate per participant, per plan year. One-time procedures are not considered an approved program.

Hospital Bill Audit Program

Program applies to only QCHP Members
The Hospital Bill Audit Program applies to hospital charges. Under the program, a member or dependent who discovers an error or overcharge on a hospital bill and obtains a corrected bill, is eligible for 50% of the resulting savings. There is no cap on the savings amount. **Note:** Related nonhospital charges, such as radiologists and surgeons, are not eligible charges under the program. The program only applies when QCHP is the primary payer.

Opt Out and Annuitant Waiver

Opt Out

In accordance with Public Act 92-0600, full-time employees, retirees, annuitants and survivors may elect to Opt Out of the State Employees Health Insurance Program if proof of other major medical insurance by an entity other than the Department of Central Management Services is provided. **This election will terminate health, dental, vision and prescription coverage for the member and any dependents.**

Members opting out of the Program continue to be enrolled with Basic Life insurance coverage only and may elect Optional Life coverage.

If you opt out of the Program you will **not be eligible** for the:

- Free influenza immunizations offered annually
- COBRA continuation of coverage
- Smoking Cessation Program

However, if you are an employee, you will **still be eligible** for the:

- Flexible Spending Account (FSA) Program
- Commuter Savings Program (CSP)
- Paid maternity/paternity benefit
- Employee Assistance Program
- Adoption Benefit Program

Opt Out With Financial Incentive

SERS Annuitants not eligible for Medicare

In accordance with Public Act 94-0109, members not eligible for Medicare receiving a retirement annuity from the State Employees' Retirement System (SERS) who are enrolled in the State Employees Health Insurance Program and have other comprehensive medical coverage may elect to OPT OUT of the Health Insurance Program and receive a financial incentive of $150 per month. Opting out includes health, vision, dental and prescription coverage for the annuitant and any dependents. Make sure to mark the 'Opt Out with Financial Incentive' box on the Benefit Choice Election Form if you are interested in this option. The Insurance Section of SERS will send you additional forms to complete that are required for this election.

Annuitant Waiver

Public Act 93-553 changed the State Employees Group Insurance Act to allow annuitants who were currently enrolled as a dependent of their State-covered spouse to remain a dependent and waive coverage in their own right, thereby decreasing the cost of coverage for an annuitant with less than 20 years of service.

New annuitants who are currently enrolled as a dependent who wish to remain enrolled as a dependent once becoming an annuitant must complete the 'Waiving Annuitant Group Insurance Coverage Notification and Election Form' which acknowledges they are waiving health, dental and vision coverage as an annuitant. The annuitant's spouse cannot carry Spouse Life on the annuitant; however, the annuitant will have Basic Life coverage and may apply for additional Optional Life coverage, if eligible.

Re-enrolling in the Health Plan

Individuals who opt out or waive under either Public Act may re-enroll in the Program only during the Benefit Choice Period, or within 60 days of experiencing an eligible qualifying change in status. Any outstanding premiums must be paid before you will be allowed to re-enroll. **Note**: Survivors and annuitants are not eligible to re-enroll if previously terminated for nonpayment of premium.

Notes

Plan Administrators

Who to contact for information

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
Quality Care Health Plan (QCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	**CIGNA** Group Number 3181456 **CIGNA HealthCare** P.O. Box 182223 Chattanooga, TN 37422-7223	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
QCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Noncompliance penalty of $800 applies	**Intracorp, Inc.**	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator QCHP (1400SD3) PersonalCare OAP (1400SCH) HealthLink OAP (1400SCF) Health Alliance Illinois (1400SBS)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	**Medco** Group Number: 1400SD3, 1400SCH, 1400SCF, 1400SBS **Paper Claims:** Medco Health Solutions P.O. Box 14711 Lexington, KY 40512 **Mail Order Prescriptions:** Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) www.medco.com
QCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	**Magellan Behavioral Health** Group Number 3181456 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Employee Assistance Program (EAP)	Confidential assistance and assessment services	**Magellan Behavioral Health** -For Non-AFSCME represented employees-	(866) 659-3848 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Personal Support Program (PSP – AFSCME EAP)	Confidential assessment and assistance services	**AFSCME Council 31** -For AFSCME represented employees-	(800) 647-8776 (statewide) (800) 526-0844 (TDD/TTY) www.afscme31.org

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Bureau of Benefits
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